Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
ORCHID MEDICAL

Respondent Name
NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number
M4-17-3396-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
JULY 20, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have included a signed certified pricing letter from the manufacturer, manufacturer invoice, op report, TX Admin code guide along with patient specific implant log. All of the appropriate documentation is attached for your review."

Amount in Dispute: $2,022.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "L8699 NU $1280.00-THE IMPLANT CHARGES IS NOT DOCUMENTED IN THE OPERATIVE REPORT…S9999-In accordance with the CMS Physician Fee schedule rule for status code 'I', this service is not separately reimbursed."

Response Submitted By: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 18, 2016	HCPCS Code L8699-NU	$1,280.00	$0.00
	HCPCS Code S9999-NU	$742.50	$0.00
TOTAL		$2,022.50	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

- B12-Services not documented inpatients' medical records.
- 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- W3-Request for reconsideration.
- 23-This procedure is not paid separately.

Issues

1. What is the applicable fee guideline?
2. Is the respondent's denial of payment supported?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The fee guidelines for professional services are found in 28 Texas Administrative Code §134.203.
2. 28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

   28 Texas Administrative Code §134.203 (b)(1) states, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   The medical bill for August 18, 2016 indicates the requestor billed HCPCS codes L8680, L8699 (X2) and S9999. Per the Table of Disputed Services, the requestor is not seeking dispute resolution for HCPCS code L8680. The disputed codes are defined as:

   - L8699- Prosthetic implant, not otherwise specified. The requestor noted that code was used for OR Cable.
   - S9999- Sales tax

   The respondent contends that reimbursement is not due for code L8699 because the documentation does not support the two units billed. A review of the Operative report does not support billing; therefore, the respondent's denial is supported.

   The respondent denied payment for code S9999 because it is included in the allowance of another service. Medicare has not covered this code since January 1, 2007. The requestor did not reference the applicable section of fee guideline to support payment of S9999. The division finds the respondent's denial is supported.

3. The division finds the requestor has not supported that reimbursement is due for the disputed services.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		8/9/2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.